State of Kansas
Department of Social and Rehabilitation Services
Disability and Behavioral Health Services – Community Supports and Services

HANDBOOK

Home and Community Based Services for Persons with Mental Retardation or who are otherwise Developmentally Disabled (HCBS-MR/DD)

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HCBS – MR/DD WAIVER:
GENERAL INFORMATION

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INTRODUCTION

The purpose of this handbook is to provide a concise collection of information about the Home and Community Based Services Medicaid Waiver for Individuals with Mental Retardation or otherwise Developmentally Disabled (HCBS-MR/DD).

The Handbook should be considered as a resource guide for consumers, families, case managers and other stakeholders in the MR/DD system. Although it contains similar information, providers of services should not consider the Handbook as a substitute or the equivalent of the Medicaid Provider Manuals for each HCBS/MR-DD service.

Copies of this handbook may be obtained through the HCP-CSS Website at;
http://www.srs.ks.gov/agency/css/Pages/DDwaiver/DevelopmentalDisabilities.aspx

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in Section 1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- Participant Access: Individuals have access to home and community-based services and supports in their communities.

- Participant-Centered Service Planning and Delivery: Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.

- Provider Capacity and Capabilities: There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.

- Participant Safeguards: Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.

- Participant Rights and Responsibilities: Participants receive support to exercise their rights and in accepting personal responsibilities.

- Participant Outcomes and Satisfaction: Participants are satisfied with their services and achieve desired outcomes.

- System Performance: The system supports participants efficiently and effectively and constantly strives to improve quality.

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework

WAIVER DESCRIPTION

The State of Kansas currently operates an approved waiver (control number 0224.90.R.2) that provides services to eligible children and adults. The purpose for this waiver is to provide the opportunity for innovation in providing Home and Community Based Services (HCBS) to eligible persons who would otherwise require institutionalization in an intermediate care facility for the mentally retarded (ICF-MR).

Consistent with the Developmental Disabilities Reform Act of 1995 (DDRA), the goals and objectives of the waiver center around the policy of the State to provide persons who have mental retardation and/or developmental disabilities access to services and supports which allow for these persons opportunities for choice that increase their independence, productivity, integration and inclusion in the community. Further, this range of supports and services will be appropriate to each person and will be provided in a manner that affords the same dignity and respect to persons with mental retardation or developmental disabilities that would be afforded to any person who does not have a disability.

Programmatic oversight and control of the waiver is provided by the Department of Social and Rehabilitation Services, Division of Disability and Behavioral Health Services/Community Supports and Services (DBHS/CSS). Consistent with the DDRA, SRS/DBHS-CSS contracts with 27 Community Developmental Disability Organizations across the state to implement requirements related to eligibility, access to services and other duties as defined by the Act.

ASSURANCES

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In accordance with 42 CFR Section 441.302, the State provides the following assurances to CMS (all references are to the Kansas HCBS-MR/DD waiver):

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to Section1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for

the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that pre-vocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are:(1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psycho-social rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR Section 440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR Section 440.160.

WAIVER SCREENING PROCESS

Individuals are screened for waiver eligibility only after they have been determined to be either mentally retarded or otherwise developmentally disabled per K.S.A. 39-1803.

The Developmental Disabilities Profile (DDP) is an assessment instrument designed to provide information concerning an individual's functional abilities in three areas: adaptive functioning, maladaptive behaviors and health. This instrument generates three scores, one for each index area, which are then combined to produce a converted score.

The following chart explains the scores in more detail, as well as the formula for the converted score. The higher the score in any index, or the higher the converted score, the greater the level of perceived disability.

	Maximum Possible	Kansas Maximum
Adaptive Index	500	500
Maladaptive Index	200	192
Health Index	31	20
Converted Score*	300	239

*formula: $\left(\frac{\text{Adaptive Score}}{\text{Kansas Max}} + \frac{\text{Maladaptive Score}}{\text{Kansas Max}} + \frac{\text{Health Score}}{\text{Kansas Max}}\right) \times 100$

For children 5 through 10, a DDP Children's Supplement must also be completed. A minimum score of 21 is required on the assessment for the child to be eligible for the HCBS-MR/DD waiver.

A converted score of 35 or greater is needed in order to meet the ICF/MR level of care criterion.

PLACEMENT INTO TIERS

Tier	Adaptive Score	Maladaptive Score	Health Score
1	455.56 - up	135.2 - up	15 - up
2	406.57 - 455.55	117.33 - 135.19	12 - 14.99
3	355.47 - 406.56	98.00 - 117.32	9 - 11.99
4	274.90 - 355.46	65.33 - 97.99	8 - 8.99
5	00.00 - 274.89	00.00 - 65.32	0 - 7.99

The results of the DDP generate a score for each of the three domains. The domain for which the persons' tier is the highest is the assigned tier for the person. For example, if a person scores a 15 or greater in the Health domain, the person's assigned tier will be tier 1 regardless of his/her scores in the other domains.

APPEALS

Both Medicaid eligibility and ICF/MR level of care eligibility decisions may be appealed. Applicants who are denied Medicaid eligibility or ICF/MR eligibility may appeal within 30 days of the notice of action by writing:

Department of Administrative Hearings
1020 S. Kansas Ave.
Topeka, Ks. 66612-1327

The regulations governing complaints, appeals and fair hearings may be found in Article 7 of the Kansas Administrative Regulations for SRS. Regulations concerning the Medicaid program may be found in Article 6. ICF/MR eligibility regulations may be found in Article 5. Eligible applicants may also file an appeal if they believe they were not offered a choice between ICF/MR services and HCBS-MR/DD.

CLIENT OBLIGATION (LIABILITY)

HCBS recipients with spenddown obligations may be required to pay a portion of, or all of, the Medicaid obligation amount to the HCBS Medicaid enrolled service provider in order to continue to receive services and thus be eligible for medical assistance.

1) The Economic and Employment Services (EES) workers determine the amount of the obligation.
2) If the recipient is receiving more than one service, the plan of care must indicate what portion of the total obligation will be applied to each service; every effort should be made to assign the total obligation to one service.
3) The provider billing for the service(s) to which the obligation is to be applied must bill the recipient for his/her obligation. Claims for reimbursement for services for which an obligation has been assigned will be reduced by the assigned amount.
4) Case managers need to inform recipients with client obligations of their responsibility to submit receipts for non-covered medical expenses to the EES worker.

Further questions and clarifications are best addressed to EES staff at the Regional SRS office.

PARENTAL FEES

During the spring of 2002, the Kansas Legislature directed the Department of SRS to start charging and collecting fees from parents to pay for a portion of services provided to their minor children. Parents whose child's eligibility was originally determined without considering parental resources or income were affected by this Legislative action.

Parents of these children share in the cost of providing services to their minor children if they have the financial means to do so, based on the parents' income and according to a sliding Parent Fee schedule. More information regarding Parental Fees can be found at http://www.srs.ks.gov/agency/css/pfp/Documents/FAQ_Revised_Feb%202010.pdf

INDIVIDUAL PLAN OF CARE

CMS requires all services funded by the HCBS waiver program be provided in accordance with an individual plan of care. The plan of care must contain the following:

1) The support needs of the participant
2) What services will be provided
3) The specific amount of services that will be provided
4) Who is responsible for meeting the needs
5) The amount of funds that the provider(s) will be reimbursed to meet the identified needs.

CDDO's, Community Service Providers and Targeted Case Managers should keep signed copies of Plans of Care on file for a minimum of 5 years. If for some reason the consumer or guardian has not signed the POC, the file should contain documentation as to the efforts made to get a copy signed.

ASSISTIVE SERVICES

1. Definition:

a) Assistive Services are supports or items that meet an individual's assessed need by improving and/or promoting the person's health, independence, productivity, or integration into the community, and are directly related to the individual's Person Centered Support Plan (PCSP) with measurable outcomes. Examples include, but are not limited to wheelchair modifications, ramps, lifts, modifications to bathrooms and kitchens (specifically related to accessibility), and assistive technology (i.e. items that improve communication, mobility or assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) in the home and work place).

b) The assistive service(s) purchased must 1) increase the consumer's ability to live independently, or 2) increase or enhance the consumer's productivity, or 3) improve the consumer's health and welfare.

2. Limitations and Restrictions:

General:

a) HCBS MR/DD Assistive Services are available to Medicaid Program beneficiaries who:

1. Are 5 years of age or older,
2. Are mentally retarded or otherwise developmentally disabled,
3. Meet the criteria for ICF/MR level of care as determined by the ICF/MR - HCBS-MR/DD screening instrument, and
4 Choose to receive HCBS-MR/DD rather than ICF/MR services.

b) HCBS MR/DD is available to minor children, ages 5-18, who are determined eligible for the Medicaid Program through a waiver of requirements relating to the deeming of parental income and who meet the criteria above.

c) All Assistive Services will be purchased under the consumer's or guardian's written authority, and paid to either the CDDO or an entity qualified by the CDDO and will not exceed the prior authorized purchase amount.

d) Purchase or rent of new or used assistive technology is limited to those items not covered through regular Medicaid.

e) No outside party can be required to subsidize an Assistive Service request. The contractor must accept full payment from Medicaid.

For Wheelchair Modifications:

a) Any wheelchair modification must be authorized by a Registered Physical Therapist and identified as medically necessary (K.A.R. 30-5-58) by a physician and identified on the recipient's Plan of Care.

b) This service can only be accessed after a recipient is no longer eligible for KAN-Be-Healthy services through the medical card.

c) Wheelchair modifications must be specific to the individual recipient's needs, and not utilized as general agency equipment.

For Van Lifts (including repair and maintenance):

a) Van lifts purchased must meet any engineering and safety standards recognized by the Secretary of the U.S. Department of Transportation.

b) Van lifts can only be installed in family vehicles or vehicles owned or leased by the recipient. No van lift should be installed in an agency vehicle unless an informed exception is made by DBHS-CSS.

For Communication Devices:

a) Communication devices will only be purchased when recommended by a Speech Pathologist.

b) Communication devices can only be accessed after a consumer is no longer eligible to receive services through the local education system.

c) Communication devices are purchased for use by the individual recipient only, not for use as agency equipment.

For Home Modifications:

a) No home modification will increase the ***finished*** square footage of an existing structure.

b) Home modifications will not be accessed for new construction.

c) Home modifications will be utilized on property where the recipient leases or

owns, in the family home if still living there, but not on agency owned and operated property unless an informed exception is made by SRS-DBHS-CSS.

3. Provider Requirements:

All providers must be State of Kansas enrolled Medicaid Providers.

Consumers will be permitted to purchase Assistive Service item(s) from any available agency in their community who is either a CDDO, an agency qualified by the CDDO, or an affiliate of the CDDO, and who agrees to furnish the specified item as identified in the PCSP.

Agencies contracted to provide home modifications include contractors and/or agencies licensed by the county or city in which they work (if required by the county or city) and will perform all work according to existing local building codes.

Assistive Services require at least two bids from companies**,** qualified by or affiliated with the CDDO, be submitted and reviewed prior to the approval of the prior authorization.

All Assistive Services will be prior authorized. The consumer or responsible party will arrange for the purchase. No work should be initiated until approval has been obtained through prior authorization.

Responsible party is defined as the persons' guardian or someone appointed by the person or guardian who is not also a paid provider of services for the person.

4. Record Keeping:

Medicaid requires written documentation of services provided and billed to the Kansas Medical Assistance Program.

Record keeping responsibilities rest primarily with the enrolled provider. Documentation must include a brief description of the service provided. Certain responsibilities may be passed to performing providers of the service. The provider must maintain a copy of the receipt identifying that the service was provided, and at a minimum the receipt must include;

- Name of the business or contractor
- Consumer's name/signature (or responsible party)
- Date of service delivery (MM/DD/YY)
- Brief description of service performed or item purchased

- A statement of inspection by the CDDO to insure the product was purchased/installed as authorized.

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for Assistive Services (1 unit = 1 purchase):

a) Assistive Services shall be billed only upon completion of all work and only after personnel from the CDDO or its' designee have inspected to assure work was completed as requested.

b) Procedure code: S5165

DAY SUPPORTS

1. Definition:

Day Supports are regularly occurring activities that provide a sense of participation, accomplishment, personal reward, personal contribution, or remuneration and thereby serve to maintain or increase adaptive capabilities, productivity, independence or integration and participation in the community. Day Supports also includes the provision of pre-vocational services which are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. These services include teaching such concepts as compliance, attendance, task completion, problem solving and safety.

Such activities shall be appropriate for or lead to a lifestyle as specified in the persons' Person Centered Support Plan (PCSP). These opportunities can include socialization, recreation, community inclusion, adult education, and skill development in the areas of employment, transportation, daily living, self sufficiency, and resource identification and acquisition.

2. Limitations and Restrictions:

a) HCBS MR/DD Day Supports is available to Medicaid Program participants who:

- meet the criteria for ICF/MR level of care as determined by ICF/MR
- (HCBS MR/DD) screening, and are determined eligible for MR/DD services, and
- are 18 years of age or older or in rare circumstances when a person is under the age of 18 in which extenuating circumstances are involved and the service has been specifically approved in writing by DBHS/CSS.

b) HCBS MR/DD Day Supports can not be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.

c) Transportation costs are NOT covered by this service.

d) Persons eligible for services through the local education authority shall not have access for reimbursement unless they are at least 18 years of age, are graduating from high school before the age of 22 and a transition plan is developed by a transition team that includes the CDDO representative or the CDDO's designee.

e) To Receive Reimbursement (5 of 7 days a week):

It is the desired outcome of DBHS/CSS that individuals receiving Day Supports have the opportunity to receive such services consistent with their preferred lifestyle a minimum of 25 hours per week. DBHS/CSS understands that each individual is unique and that this outcome can be met in a variety of ways.

Individuals must be out of their home a minimum 5 hours per day, or a total of 25 hours per week unless;

- a person operates a home based business, or;
- a person is unable to be out of their home due to a medical necessity or significant physical limitations related to frailty and for which a physician has provided current (within the past 185 days and reviewed at least every 185 days thereafter) written verification for the necessity to remain in the home.

Those persons eligible to receive services while they remain in the home must participate in activities consistent with their Person Centered Support Plan and to the extent possible, replicate activities in which the person would be participating if they were out of the home.

For persons who prefer to not receive day supports five days per week, supporting documentation consistent with this preference should be available in his/her Person Centered Support Plan.

f) Supported employment activities must not be provided until the individual has applied to the local Rehabilitation Services office. HCBS/DD Waiver will fund supported employment activities until the point in time when Rehabilitation Services funding for supported employment begins. HCBS-MR/DD waiver funded supported employment activities must not be provided simultaneously with activities directly reimbursed by Kansas Vocational Rehabilitation Services.

3. Provider Requirements:

Providers of MR/DD Day Supports must;

- Be a recognized Community Developmental Disability Organization (CDDO) or a licensed Community Service Provider affiliated with the CDDO.
- Be a Medicaid Enrolled Provider.

4. **Record Keeping**:

Written documentation is required for services provided and billed to the Kansas Medical Assistance Program. Record keeping responsibilities rest primarily with the provider. ***At a minimum,*** documentation must consist of an attendance record indicating whether the beneficiary was present. The minimum components of an attendance sheet include;

- The name of the service
- Consumer's first and last name
- The date(s) of the service provided (MM/DD/YY)
- A check mark to indicate the beneficiary received the service as defined
- Signature of a responsible staff person verifying the information is correct.

If the beneficiary did not receive a full day of service, then some alternate mark should be used to indicate what portion of the service was provided on that date. Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for Day Supports:

a) To receive reimbursement for 5 of 7 days a week, the provider must document that services were provided at least 25 hours during the Community Service Providers' defined seven day week. This may be accomplished through documentation that indicates the person received more than 5 hours of supports on some days and less than 5 hours per day on other days. For persons receiving less than 25 hours of supports within the Community Service Providers' defined seven day week, time may be accumulated and then billed for the appropriate number of full and/or partial units. Time may not be carried over from one defined seven day week to the next defined seven day week.

b) Day Supports are billed at a daily tiered rate (1 unit = 1 day)

Tier 1 _____	Super Tier 1_____
Tier 2 _____	Super Tier 2_____
Tier 3 _____	Super Tier 3_____
Tier 4 _____	Super Tier 4_____
Tier 5 _____	Super Tier 5_____

c) An individual may choose to self-direct all or a portion of his/her Day Supports by converting the necessary Day Supports funding to Personal Assistant Services in a manner consistent with the Personal Assistant Services section.

d) Procedure code: T2020

MEDICAL ALERT RENTAL

1. Definition:

The purpose of this service is to provide support to a consumer who has a medical need that could become critical at anytime. The medical alert device is a small instrument carried or worn by the consumer which, by the push of a button, automatically dials the telephone of a predetermined responder who will answer the call for help.

The following are examples of medical needs that might require this service:

- quadriplegia
- severe heart conditions
- difficult to control diabetes
- severe convulsive disorders
- severe chronic obstructive pulmonary disease
- head injury

2. Limitations and Restrictions:

a) HCBS MR/DD Medical Alert Rental is available to Medicaid Program participants who:
   - meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MR/DD) screening, and
   - are determined eligible for MR/DD services.

b) HCBS MR/DD is available to minor children, ages 5-18, who are determined eligible for the Medicaid Program through a waiver of requirements relating to the deeming of parental income and who meet the criteria above.

c) Rental, not the purchase, of this equipment is covered.

3. Provider Requirements:

Examples of qualified Medicaid-enrolled providers of this service include, but are not limited to; agencies, hospitals, and emergency transportation service companies.

4. Record Keeping:

At a minimum, record keeping will include;

- Service Provider's name
- The name of the service provided
- Date of Invoice or Statement (MM/DD/YY)
- The name of the Beneficiary(ies)
- Month of coverage (MM/YY)
- Cost of Service

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims.

5. Billing for Medical Alert Rental:

Reimbursement for Medical Alert Rental is based on a monthly rate of _____.

Procedure code: S5161

SLEEP CYCLE SUPPORT
(formerly called Night Support)

1. Definition:

Sleep Cycle Support services are provided to individuals who live with someone meeting the definition of family, or are provided to children in the custody of SRS residing in a setting that does not meet the definition of family. Family is defined as any person immediately related to the beneficiary of services. Immediate related family members are: parents (including adoptive parent), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any step-family relationships.

The primary purpose of Sleep Cycle Support is to give overnight assistance to recipients in case of emergencies or to assist with repositioning. A Sleep Cycle Support attendant is ready to call a doctor, hospital, or provide other assistance if an emergency occurs. The attendant must be immediately available, but can sleep when not needed. The duties of a night support attendant include:

- Calling a doctor or hospital, or providing other assistance if an emergency occurs,
- Turning and repositioning the beneficiary,
- Assistance with peri-care and/or toileting
- Reminding the beneficiary of nighttime medication, or
- Administration of medication when necessary.

The attendant does not perform any other personal care, training, or homemaker tasks. Individuals/entities who are affiliated with the CDDO, who may or may not be licensed by SRS for other purposes, will provide this service.

2. Limitations and Restrictions:

a) HCBS MR/DD Sleep Cycle Support is available to Medicaid program beneficiaries who:

1. Are 5 years of age or older,
2. Are mentally retarded or otherwise developmentally disabled,
3. Meet the criteria for ICF/MR level of care as determined by the ICF/MR (HCBS MR/DD) screening instrument, and
4 Choose to receive HCBS - MR/DD rather than ICF/MR services.

b) HCBS MR/DD is available to minor children, ages 5-18, who are determined eligible for the Medicaid Program through a waiver of requirements relating to the deeming of parental income and who meet the criteria above.

c) Sleep Cycle Support can not be provided by a recipient's spouse or by a parent of a recipient who is a minor child under eighteen years of age.

d) Sleep Cycle Support recipients may not also receive residential supports.

e) Sleep Cycle Support can not be provided to a recipient who is an inpatient of a hospital, a nursing facility, or an ICF/MR when the inpatient facility is billing Medicaid, Medicare and/or private insurance.

f) The period of service for Sleep Cycle Support is a minimum of 8 hours and cannot exceed 12 hours

g) The service is limited to recipients unable to be alone at night due to anticipated MEDICAL problems only.

h) A statement of medical necessity signed by a physician must be on record.

i) A self-direct option may be chosen for Sleep Cycle Support by the individual or, if the person is not capable of providing self-direction, by the individual's guardian or person acting on their behalf.

3. Provider Requirements:

The Sleep Cycle Support provider must be affiliated with the Community Developmental Disability Organization (CDDO) for the area(s) where it operates. As indicated in K.A.R. 30-63-10, any individual providing services is at least 16 years of age, or at least 18 years of age if a sibling of the recipient of service.

4. Record Keeping:

Record keeping responsibilities rest primarily with the enrolled provider.

At a minimum, documentation must include;

- Consumer's name, signature (or responsible party) if self-directing
- Caregiver's name/signature
- Date of service
- Start time for each visit
- End time for each visit
- Each entry dated and initialed by Sleep Cycle Support provider
- Brief description of duties performed

Documentation must include a brief description of the service provided as well as the number of hours spent with the beneficiary. Each entry must be dated and signed by the individual who provided the service.

If a provider is hired and the work is being directed by a beneficiary's family member or the beneficiary him/herself, then billings should be made through the CDDO or an agent that is affiliated with the CDDO that will account for all necessary deductions including; taxes, unemployment, and workmen's compensation, as applicable. Proof of compliance must be presented to the CDDO.

Medicaid requires written documentation of services provided and billed to the Kansas Medical Assistance Program.

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for Sleep Cycle Support:

Sleep Cycle Support may be billed on a daily rate and the services provided must meet the participant's support needs for a minimum of eight hours but not more than twelve hours,

1 unit = 1 day, at a rate of _____ per day.

Procedure code: T2025

SPECIALIZED MEDICAL CARE

1. Definition:

This service provides long-term nursing support for medically-fragile and technology-dependent beneficiaries. The required level of care must provide medical support for beneficiaries needing ongoing, daily care that would otherwise require the beneficiary to be in a hospital. The intensive medical needs of the beneficiary must be met to ensure that the person can live outside of a hospital or intermediate care facility for persons with mental retardation.

For the purpose of this waiver, a provider of Specialized Medical Care must be an RN or an LPN under the supervision of an RN, or another entity designated by the Kansas Department of Social and Rehabilitation Services, Department of Disability and Behavioral Health Services (SRS-DBHS). Providers of this service must be trained with the medical skills necessary to care for and meet the medical needs of beneficiaries within the scope of the State's Nurse Practice Act.

The service may be provided in all customary and usual community locations including where the beneficiary resides and socializes.

It is the responsibility of the provider agency to ensure that qualified nurses are employed and able to meet the specific medical needs of the beneficiaries.

Specialized Medical Care does not duplicate any other Medicaid state plan service or other services available to the beneficiary at no cost.

Providers of this service will be reimbursed for medically appropriate and necessary services relative to the level of need as identified in the POC.

2. Limitations and Restrictions:

a) HCBS MR/DD Specialized Medical Care services are available to Medicaid program beneficiaries who:

   1. Are five years of age or older,
   2. Are mentally retarded or otherwise developmentally disabled,
   3. Meet the criteria for ICF/MR level of care as determined by the ICF/MR – HCBS-MR/DD screening instrument, and
   4. Choose to receive HCBS-MR/DD rather than ICF/MR services

b) Specialized Medical Care services may not be provided by a recipient's spouse or by a parent of a recipient who is a minor child under eighteen years of age.

c) Specialized Medical Care Services recipients may not also receive Residential Supports or Personal Assistant Services as an alternative to Residential Supports.

d) Specialized Medical Care services are limited to a maximum of an average of twelve hours per day or 372 hours or 1488 units per month. One unit is equal to 15 minutes.

e) Services furnished to a beneficiary who is an inpatient or resident of a hospital, nursing facility, ICF/MR, or IMD are not reimbursable.

f) A beneficiary can receive Specialized Medical Care services from more than one worker, but no more than one worker can be paid for services at any given time of the day. A Specialized Medical Care provider cannot be paid to provide services to more than one beneficiary at any given time of day.

3. Provider Requirements:

Providers of Specialized Medical Care services are limited to skilled nursing staff (RN or LPN) licensed to practice in Kansas under the employment and direct supervision of a home health agency (HHA) licensed by the Kansas Department of Health and Environment (KDHE) or another entity approved by SRS/DBHS. Other entities must have a letter from the MR/DD Program Manager stating that they are a qualified provider of Specialized Medical Care Services.

Providers of Specialized Medical Care must be affiliated with the Community Developmental Disability Organization (CDDO) for the area where they operate.

4. Record Keeping:

Record keeping responsibilities rest primarily with the enrolled provider. A description of expectations for the Specialized Medical Care providers must be maintained and available for review. The descriptions are subject to audit.

Documentation must include a brief description of the service provided and must also include information about the access, appropriateness, and coordination of supports and services. Documentation must also include the number of hours spent with the beneficiary. Each entry must be dated and signed by the individual who provided the service.

Medicaid requires written documentation of services provided and billed to the Kansas Medical Assistance Program. Documentation at a minimum must include the following:

- Name of the service
- Consumer's name, signature (or responsible party)
- Each entry dated and signed by Specialized Medical Care Provider
- Start time for each visit (am/pm or utilize 2400 clock hours)

- End time for each visit (am/pm or utilize 2400 clock hours)
- A brief description of duties performed

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5. Reimbursement:

- Providers of Specialized Medical Care must be affiliated with the Community Developmental Disability Organization (CDDO) for the area where they operate.

- Payment for Specialized Medical Care may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Specialized Medical Care services may be billed on a quarter-hourly rate (1 unit = 15 minutes);

Procedure Code T1000TD for RN level of care or;

Procedure Code T1000 for LPN level of care.

PERSONAL ASSISTANT SERVICES

1. Definition:

a) Personal Assistant Services are available to individuals who choose to receive services in a setting that would otherwise be considered a setting requiring services to be provided by an entity licensed by DBHS-CSS. This service provides necessary ***one-to-one*** assistance for individuals both in their home and community.

b) Personal Assistant Services means one or more personal assistants assuring the health and welfare of the individual and supporting the individual with the tasks the person would typically do for themselves or by themselves if they did not have a disability. Such services include assisting individuals in performing a variety of tasks promoting independence, productivity, integration, and inclusion.

Personal Assistant Services include assisting with activities of daily living - ADLs (bathing, grooming, toileting, transferring, health maintenance activities including but not limited to extension of therapies, feeding, mobility and exercises), independent activities of daily living - IADLs (shopping, housecleaning (related to the recipient), seasonal chores, meal preparation, laundry, financial management) and support services - SS (socialization and recreation activities), assistance in obtaining necessary medical services assistance in reporting changes in the individual's condition and needs, and accompanying or providing transportation to accomplish any off the tasks listed above.

2. Limitations and Restrictions:

General:

HCBS MR/DD Personal Assistant Services are available to Medicaid Program participants who are at least 18 years of age; and,

Meet the criteria for ICF/MR level of care as determined by the ICF/MR (HCBS MR/DD) screening instrument.

Choose to receive HCBS MR/DD rather than ICF/MR services.

Receive services in a setting that would otherwise require that the services provided in that setting to be licensed by SRS-DBHS/CSS.

Agree to self-direct their services.

Specific Limitations and Restrictions:

a) It is the expectation that waiver recipients who need assistance with independent activities of daily living (IADL) tasks and who live with their spouse or guardian who is capable of performing the IADL tasks, should rely on these informal/natural supporters for this assistance unless there are extenuating or specific circumstances that have been documented in the Person-Centered Support Plan (for example, the PCSP defines the role of the Personal Assistant as a person who is teaching the recipient how to perform the skill). In accordance with this expectation, Personal Assistant Services should not be used for;

- Lawn care;
- Snow removal;
- Shopping;
- Ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the recipient lives);
- Meal preparation during the times when the person with whom the recipient lives would normally prepare a meal for themselves.

b) All Personal Assistant Services will be arranged for, and purchased under the individuals' or responsible party's written authority, and paid through an enrolled fiscal agent consistent with and not exceeding the individual's Plan of Care. Individuals will be permitted to choose qualified provider(s) who have passed background checks that assure compliance with KAR 30-63-28(f) and the DBHS/CDDO Background Check Policy.

c) Individual's who may at some point determine that they no longer wish to continue to self-direct their Personal Assistant Services will have the opportunity to receive their previously approved waiver services, without penalty**.**

d) A Personal Assistant may not perform any duties for the individual that would otherwise be consistent with the Supported Employment definition, Sections 1.a & b.

e) Personal Assistant Services cannot be provided to an individual who is an inpatient of a hospital, a nursing facility, or an ICF/MR when the inpatient facility is billing Medicaid, Medicare and/or private insurance, with the exception of f) below.

f) Personal Assistant retainer services may billed and the Personal Assistant paid up to a maximum of 14 days per calendar year, at a level consistent with the approved Plan of Care. These services are provided during time when the individual is an inpatient of a hospital, a nursing facility, or an ICF/MR when the facility is billing Medicaid, Medicare and/or private insurance and are provided to assist individuals who self-direct their care with retaining their current care provider(s).

g) Individuals in Residential Supports can not also receive Personal Assistant Services for the same Residential Supports, or any of the Family/Individual Supports array of services. (This does not prevent the conversion of Day Supports to Personal Assistant Services).

3. Provider Requirements:

a) As indicated in K.A.R. 30-63-10, any Personal Assistant providing services must be at least 16 years of age, or at least 18 years of age if a sibling of the individual. The Personal Assistant Services cannot be provided by the Legal Guardian for the recipient.

b) Providers must be either a CDDO or an affiliate of the CDDO who would be functioning as a payroll agent**.**

c) Consistent with K.A.R. 30-63-10, the participant, or the individual directing and controlling the services on the persons' behalf, is responsible for documenting that the individual Personal Assistant provider has received sufficient training to meet the participant's needs. Written certification must be provided to the Community Developmental Disability Organization (CDDO).

d) Providers are required to pass background checks consistent with the SRS Background Check Policy and comply with all regulations related to Abuse, Neglect and Exploitation.

4. Record Keeping:

Record keeping responsibilities rest primarily with the Medicaid Enrolled Provider (which will most often be the fiscal agent). Documentation must include a brief description of the service provided as well as the number of hours spent with the individual.

Medicaid requires written documentation of services provided and billed to the Kansas Medical Assistance Program.

Documentation at a minimum must include:

- Individual's name/signature (or responsible party)
- Personal Assistant's name/signature
- Complete Dates of Service (MM/DD/YY)
- Start time for each visit (am/pm or utilize 2400 clock hours)
- End time for each visit (am/pm or utilize 2400 clock hours)
- Brief description of duties performed
- Each entry dated and initialed by Personal Assistant

Responsible party is defined as the persons' guardian or someone appointed by the person or guardian who is not also a paid provider of services for the person.

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. **Billing for Personal Assistant Services:**

An individual may choose to self-direct his/her supports by converting the licensed Residential Supports and/or Day Supports funding to Personal Assistant Services. The total monthly cost of Personal Assistant Services may not exceed the total monthly-tiered and combined Residential Supports and Day Supports rates. In other words, the conversion must be cost neutral. Personal Assistant Services are limited to a monthly maximum of an average of 12 hours per day/per month

Individuals choosing to convert Day Supports funding must continue to meet the out of home requirements as set forth in the Day Supports definition.

1 unit = 15 minutes, at a rate of _____ per 15 minutes.

Procedure code: T1019

RESIDENTIAL SUPPORTS

1. Definition:

These supports are provided to waiver recipients who live in a residential setting and do not live with someone meeting the definition of family. Family is defined as any person immediately related to the beneficiary of services. Immediate related family members are; parents (including adoptive parents), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any step-family relationships.

This service provides assistance, acquisition, retention and/or improvement in skills related to activities of daily living, such as, but not necessarily limited to, personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for Residential Supports are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to the facility required to assure the health and safety of individuals or to meet the requirements of the applicable life safety code. Payment for Residential Supports does not include payments made directly to members of the individual's immediate family. Payments will not be made for routine care and supervision which would be expected to be provided by immediate family members or for which payment is made by a source other than Medicaid.

2. Limitations and Restrictions

General:

a) HCBS MR/DD Residential Supports are available to individuals in the Medicaid Program who:

- Are 5 years of age or older, and
- Are mentally retarded or otherwise developmentally disabled, and
- Meet the criteria for ICF/MR level of care as determined by the ICF/MR (HCBS MR/DD) screening instrument, and
- Choose to receive HCBS MR/DD rather than ICF/MR services.

b) HCBS MR/DD Residential Supports can NOT be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.

c) Room, board and transportation are NOT covered by this service.

d) Individuals receiving Residential Supports can NOT also receive Personal Assistant Services, ~~or any of the Family/Individual Supports array of services~~ ***Supportive Home Care services or Overnight Respite Services***. (This does not prevent the conversion of Day Supports to Personal Assistant Services).

e) Residential Supports can NOT be provided in the home of the beneficiary's family. Services may be provided to a beneficiary in his/her own home or apartment as long as the community service provider is licensed by SRS to provide this service.

Residential Services for Adults;

Residential Supports for adults are provided for individuals 18 years of age or older and must occur in a setting**,** without regard to siblings**,** where the person does not live with someone who meets the definition of family, and are provided by entities licensed by Community Supports and Services.

HCBS MR/DD Residential Supports will NOT be offered in a setting nine beds or larger in size.

Residential Supports for Children who are not in SRS Custody;

Residential Supports are available to minor children, ages 5 through 21 (eligibility ends on the 22nd birthday) years of age who are determined eligible for the Medicaid Program through a waiver of requirements relating to the deeming of parental income. Children's Residential Services shall be provided outside the family home in a home which:

1. is licensed by KDHE as a family foster home, meets all State or SRS/CFP requirements, or is another residential setting that is approved by SRS/DBHS, and;

2. serves no more than two (2) children unrelated to the family foster care provider, and in which no more than two individuals funded with State or Medicaid money reside, and;

3. is located in or near the child's home community and school so the child remains in contact with the natural family, if appropriate, and maintains established community connections such as but not limited to; the child's school and teachers, friends and neighbors, community activities, church and health care professionals.

In addition, the Children's Residential Services provider will;

- Cooperate with case management, the school district, and any consultants in designing and implementing specialized training procedures.

- Actively participate in Individual Education Plan development and the public school education program.

- Have a documented back-up plan, coordinated by the agency responsible for the child's placement that, in the event the setting disrupts, includes the provision of services until an alternate community-based placement is found and a transition meeting occurs that includes, at a minimum, the CDDO.

Persons at least 18 years of age who are receiving Children's Residential Services may continue to receive those services until their 22nd birthday or may transfer to Adult Residential Services, whichever is most consistent with the person's preferred lifestyle.

3. Provider Requirements:

Providers of MR/DD Residential Supports must;

- Be a recognized Community Developmental Disability Organization (CDDO) or a licensed Community Service Provider affiliated with the CDDO.
- Be a Medicaid Enrolled Provider.

All providers of Residential Supports shall be in compliance with K.A.R. Article 30-63-21 through 30-63-30.

4. Record Keeping:

Record keeping responsibilities rest primarily with the provider. Documentation must include an attendance record indicating whether the beneficiary was present for the provision of service.

The minimum components of an attendance sheet include:

- the name of the service
- Consumer's first and last name
- the date(s) of the service provided, (MM/DD/YY)
- a check mark to indicate the individual received the service as defined, and a signature of a responsible staff person verifying the information is correct.

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for Residential Supports:

a) Residential Supports are billed at a daily tiered rate (1 unit = 1 day)

Tier 1 _____	Super Tier 1_____
Tier 2 _____	Super Tier 2_____
Tier 3 _____	Super Tier 3_____
Tier 4 _____	Super Tier 4_____
Tier 5 _____	Super Tier 5_____

b) In order to bill for the daily rate, the individual must be present for supports to be provided. Also, it must be documented that the supports were provided and/or the provider was available to provide the necessary supports to the individual, if needed.

c) On an aggregated basis, no more than 20% of the tiered reimbursement can be retained by the Child Placing Agency to defray administrative costs.

d) An individual may choose to self-direct his/her supports by converting their Residential Supports funding to Personal Assistant Services in a manner consistent with the Personal Assistant section.

e) Procedure code: T2016

SUPPORTED EMPLOYMENT

1. Definition:

a) Supported Employment is competitive work in an integrated setting with on-going support services for individuals who have MR/DD. Competitive work is work for which an individual is compensated in accordance with the Fair Labor Standards Act. An integrated work setting is a job site that is similar to that of the general work force. Such work is supported by any activity needed to sustain paid employment by persons with disabilities.

b) The following supported employment activities are designed to assist individuals in acquiring and maintaining employment:

- Individualized assessment.
- Individualized job development and placement services that create an appropriate job match for the individual and the employer.
- On the job training in work and work related skills required to perform the necessary functions of the job.
- Ongoing monitoring of the individuals performance on the job.
- Ongoing support services necessary to assure job retention as identified in the person-centered support plan.
- Training in related skills essential to secure and retain employment.

2. Limitations and Restrictions:

a) HCBS MR/DD Supported Employment Services are available to Medicaid Program participants who:

- meet the criteria for ICF/MR level of care as determined by ICF/MR (HCBS MR/DD) screening, and
- are determined eligible for MR/DD services, and
- are 18 years of age or older.

b) HCBS MR/DD can NOT be provided to anyone who is an inpatient of a hospital, a nursing facility, or an ICF/MR.

c) Transportation costs are NOT covered by this service.

d) Persons eligible for services through the local education authority shall not have access for reimbursement unless they are at least 18 years of age, are graduating from high school before the age of 22 and a transition plan is developed by a transition team that includes the CDDO representative or the CDDO's designee.

e) Supported employment activities must not be provided until the individual has applied to the local Rehabilitation Services office. HCBS/DD Waiver will fund supported employment activities until the point in time when Rehabilitation Services funding for supported employment begins. HCBS-MR/DD waiver funded supported employment activities must not be provided simultaneously with activities directly reimbursed by Kansas Vocational Rehabilitation Services.

f) Supported Employment cannot be provided in a sheltered work setting.

3. Provider Requirements:

Providers of MR/DD Supported Employment Services must;

- Be a recognized Community Developmental Disability Organization (CDDO) or a licensed Community Service Provider affiliated with the CDDO.
- Be a Medicaid Enrolled Provider.

4. Record Keeping:

Record keeping responsibilities rest primarily with the provider. At a minimum, documentation must include:

- Individual's name/signature (or responsible party)
- Supported Employment Provider's name/signature
- Complete Date of Service (MM/DD/YY)
- Start time for each activity (am/pm or utilize 2400 clock hours)
- End time for each activity (am/pm or utilize 2400 clock hours)
- Brief description of duties performed
- Each entry dated and initialed by Supported Employment Staff

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for Supported Employment:

a) The monthly cost for Supported Employment, or the monthly cost of a combination of Supported Employment and Day Supports, cannot exceed the monthly cost that would be approved for Day Supports. If the person is using a combination of Day Supports and Supported Employment, either service may be billed for the maximum number of hours it was provided and prior-authorized, not to exceed 25 total hours of services per week.

b) 1 unit = 15 minutes at a rate of _____ per 15 minutes.

Procedure code: H2023

SUPPORTIVE HOME CARE

1. Definition:

Supportive Home Care services are provided to individuals who live with someone meeting the definition of family, or are provided to children in the custody of SRS residing in a setting that does not meet the definition of family. Family is defined as any person immediately related to the beneficiary of services. Immediate related family members are: parents (including adoptive parent), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any step-family relationships.

These are individualized (one-to-one) services that provide direct assistance to waiver recipients in daily living and personal adjustment, attendant care, assistance with medications that are ordinarily self-administered and accessing medical care, supervision, reporting changes in the recipient's condition and needs, extension of therapy services, ambulation and exercise, household services essential to health care at home or performed in conjunction with assistance in daily living (e.g. shopping, meal preparation, clean-up after meals, bathing, using appliances, dressing, feeding, bed-making, laundry and cleaning the bathroom and kitchen) and household maintenance related to the recipient. The Supportive Home Care worker can accompany or transport the recipient to accomplish any of the tasks listed above to provide essential supervision or support for community activities.

2. Limitations and Restrictions:

a) HCBS MR/DD Supportive Home Care is available to Medicaid program beneficiaries who:

1. Are 5 years of age or older,
2. Are mentally retarded or otherwise developmentally disabled,
3. Meet the criteria for ICF/MR level of care as determined by the ICF/MR - HCBS-MR/DD screening instrument, and
4 Choose to receive HCBS-MR/DD rather than ICF/MR services.

b) HCBS MR/DD is available to minor children, ages 5-18, who are determined eligible for the Medicaid Program through a waiver of requirements relating to the deeming of parental income and who meet the criteria above.

c) Supportive home care may not be provided by a recipient's spouse or by a parent of a recipient who is a minor child under eighteen years of age.

d) Supportive Home Care recipients may not also receive Residential Supports or Personal Assistant Services as an alternative to Residential Supports.

e) Supportive Home Care (SHC) services may not be provided in an educational setting and may not be used for education or as a substitute for educationally related services or for transition services as outlined in the individual's Individual Education Plan. In order to verify that SHC services are not used as a substitute, an SHC services Schedule (MR-10), or the In-Home Supports Needs Assessment**,** should clearly define the division of educational services and SHC services. Educational services should be equal to or greater than seven hours per day in which school is regularly in session. These hours do not have to be consecutive hours. The minimal numbers of hours required for kindergarten students is seven hours per day for those who are eligible for full-day kindergarten services and three and-a-half hours per day for those students who are eligible for half-day kindergarten.

f) Supportive home care services are limited to a maximum of an average of eight hours per day in any given month, and to only the activities described above unless sufficient rationale is provided for the approval of hours in excess of an average of eight hours per day. The absolute maximum allowable supportive home care is an average of twelve hours per day in any given month.

g) ~~Supportive home care hours are provided ONLY when the primary care givers are present OR regularly scheduled to be absent; otherwise, respite hours should be utilized.~~

h) A recipient can receive supportive home care services from more than one worker, but no more than one worker can be paid for services at any given time of the day.

i) Supportive home care services can not be provided to a recipient who is an inpatient of a hospital, a nursing facility, or an ICF/MR when the inpatient facility is billing Medicaid, Medicare and/or private insurance except as provider for in k) below.

j) It is the expectation that waiver recipients who need assistance with independent activities of daily living (IADL) tasks and who live with someone meeting the definition of family who is capable of performing the IADL tasks, should rely on these informal/natural supporters for this assistance unless there are extenuating or specific circumstances that have been documented in the Person-Centered Support Plan (for example, the PCSP defines the role of the SHC provider as a person who is teaching the recipient how to perform the skill). In accordance with this expectation, supportive home care should not be used for;

- Lawn care;
- Snow removal;
- Shopping;
- Ordinary housekeeping (as this is a task that can be completed in conjunction with the housekeeping/laundry done by the individual with whom the recipient lives);
- Meal preparation during the times when the person with whom the recipient lives would normally prepare a meal for themself/themselves**.**

k) Supportive Home Care retainer services may billed up to a maximum of 14 days per calendar year, at a level consistent with the approved Plan of Care. These services are provided during time when the individual is an inpatient of a hospital, a nursing facility, or an ICF/MR when the facility is billing Medicaid, Medicare and/or private insurance and are provided to assist individuals who self-direct their care with retaining their current care provider(s).

l) Supportive Home Care services can be provided to children from 5 to 22 years of age and reside outside the family home in a home which;

1. is licensed by KDHE as a family foster home, meets all state or SRS/CFP requirements, or is another residential setting that is approved by SRS/DBHS;

2. serves no more than two (2) children unrelated to the family foster care provider, and;

3. is located in or nears the child's home community and school so the child remains in contact with the natural family, if appropriate, and maintains established community connections such as but not limited to; the child's school and teachers, friends and neighbors, community activities, church and health care professionals**.**

3. Provider Requirements:

Providers of Supportive Home Care must be affiliated with the Community Developmental Disability Organization (CDDO) for the area where they operate. As indicated in K.A.R. 30-63-10, any individual providing services is at least 16 years of age or at least 18 years of age if a sibling of the recipient of service. All individuals providing services to persons who are NOT self-directing their services must receive at least 15 hours of prescribed training from the authorized Medicaid provider, or for those persons whose services are considered self-directed, written certification must

be provided to the Community Developmental Disability Organization (CDDO) that sufficient training has been provided to meet the recipient's needs.

A self-direct option may be chosen for supportive home care by the individual or, if the person is incapable of providing self-direction, by the individuals' guardian or family member, or person acting on their behalf.

4. Record Keeping:

Record keeping responsibilities rest primarily with the enrolled provider. A description of expectations for supportive home care workers must be maintained and available for review. The descriptions are subject to audit. If services are being provided to children accessing services from the Local Education Authority, a separate description of expectations for supportive home care workers (one for when in school and one for when not in school) may be appropriate and must also be available for review. The descriptions are also subject to audit.

Documentation must include a brief description of the service provided as well as the number of hours spent with the beneficiary. Each entry must be dated and signed by the individual who provided the service.

If a provider is hired and the work is being directed by a beneficiary's family member or the beneficiary him/herself, then billings should be made through the CDDO or an agent that is affiliated with the CDDO that will account for all necessary deductions including; taxes, unemployment, and workmen's compensation, as applicable. Proof of compliance must be presented to the CDDO.

Medicaid requires written documentation of services provided and billed to the Kansas Medical Assistance Program. Documentation at a minimum must include the following:

- Consumer's name, signature (or responsible party) if self-directing
- Caregiver's name/signature
- Date of service
- Each entry dated and initialed by Supportive Home Care provider
- Start time for each visit (am/pm or utilize 2400 clock hours)
- End time for each visit (am/pm or utilize 2400 clock hours)
- Brief description of duties performed

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for Supportive Home Care:

Supportive Home Care services may be billed on a quarter-hourly rate (1 unit = 15 minutes) at a rate of _____ per 15 minutes.

Procedure code: S5125

OVERNIGHT RESPITE CARE

1. Definition

~~Temporary and~~ Overnight Respite Care services are provided to individuals who live with someone meeting the definition of family, or are provided to children in the custody of SRS residing in a setting that does not meet the definition of family. Family is defined as any person immediately related to the beneficiary of services. Immediate related family members are: parents (including adoptive parent), grandparents, spouses, aunts, uncles, sisters, brothers, first cousins and any step-family relationships.

Overnight Respite Care is designed to provide relief for the individual's family member who serves as an unpaid primary care giver. ~~Respite is necessary for families who provide constant care for individuals so family members are able to receive periods of relief for vacations, holidays and scheduled periods of time off~~.

2. Limitations and Restrictions:

~~Respite care is provided in planned or emergency segments and may include payment during the individual's sleep time limited to a maximum of two hours before and after the individual is due to wake up or go to bed.~~

a) HCBS MR/DD Overnight Respite is available to Medicaid Program consumers who:

- Are 5 years of age or older;
- Are mentally retarded or otherwise developmentally disabled;
- Meet the criteria for ICF/MR level of care as determined by the ICF/MR (HCBS MR/DD) screening instrument;
- Choose to receive HCBS MR/DD rather than ICF/MR services and
- Have a family member who serves as the primary care giver who is not paid to provide any HCBS-MR/DD service for the individual.
- HCBS-MR/DD respite is available to minor children, 5-18, who are determined eligible for the Medicaid Program through a waiver of requirements relating to the deeming if parental income and who meet the criteria above.

b) ***Overnight*** Respite care may not be provided by a consumer's spouse OR by a parent of a consumer who is a minor child under eighteen years of age.

c) Individuals who receive ***Overnight*** Respite Care services may not also receive Residential Supports or Personal Assistant Services as an alternative to Residential Supports.

d) ***Overnight*** Respite care services cannot be provided to an individual who is an inpatient of a hospital, a nursing facility, or an ICF/MR when the inpatient facility is billing Medicaid, Medicare and/or private insurance.

e) Room and board is not part of the cost of service unless provided as part of respite care in a facility approved by the state that is not a private residence.

f) Overnight Respite Care may be provided in the following location(s) and will allow for staff to sleep:

- Individual's family home or place of residence;
- Licensed Foster Home;
- Facility approved by KDHE or SRS which is not a private residence, or;
- Licensed Respite Care Facility/Home.

g) A maximum of 60 nights of overnight respite per calendar year is allowed.

h) ~~Temporary and~~ Overnight Respite services can be provided to children from 5 to 22 years of age and reside outside the family home in a home which;

1. is licensed by KDHE as a family foster home, meets all state or SRS/CFP requirements, or is another residential setting that is approved by SRS/DBHS;
2. serves no more than two (2) children unrelated to the family foster care provider, and;
3. is located in or nears the child's home community and school so the child remains in contact with the natural family, if appropriate, and maintains established community connections such as but not limited to; the child's school and teachers, friends and neighbors, community activities, church and health care professionals.

3. **Provider Requirements:**

Providers of ***Overnight*** Respite Care must be affiliated with the Community Developmental Disability Organization (CDDO) for the area where they operate. Providers of overnight facility-based respite care for minor children must be licensed by KDHE. Providers of overnight facility-based respite care for adults must be licensed by SRS-DBHS/CSS**.**

A self-direct option may be chosen for ***overnight*** respite care by the individual or, if the person is not capable of providing self-direction, by the individual's guardian or person` acting on their behalf.

4. Record Keeping:

Record keeping responsibilities rest primarily with the enrolled provider. Documentation must include a brief description of the service provided as well as the number of hours spent with the beneficiary. Each entry must be dated and signed by the individual who provided the service.

If a provider is hired and the work is being directed by a beneficiary's family member or the beneficiary him/herself, then billings should be made through the CDDO or an agent that is affiliated with the CDDO that will account for all necessary deductions including; taxes, unemployment, and workmen's compensation, as applicable. Proof of compliance must be presented to the CDDO.

Medicaid requires written documentation of services provided and billed to the Kansas Medical Assistance Program.

Documentation at a minimum must include the following:

- Consumer's name, signature (or responsible party) if self-directing
- Caregiver's name/signature
- Date of service
- Each entry dated and initialed by ***Overnight*** Respite Care provider
- Start time for each visit
- End time for each visit
- Brief description of duties performed

Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for *Overnight* Respite Care:

~~a) Respite Care services are be billed on a quarter-hourly rate (1 unit = 15 minutes) at a rate of _____ per 15 minutes. (Maximum of 330 hours per calendar year.)~~

~~Procedure code:~~ S5150

~~b)~~ Overnight Respite Care is be billed on a daily rate and the services provided must meet the participant's support needs for a minimum of eight hours but not more than twelve hours.

Overnight respite services are billed on a daily rate (1 unit = 1 day) at a rate of _____ per day. (Maximum of 60 nights per calendar year)

Procedure code: H0045

WELLNESS MONITORING

1. Definition:

Wellness Monitoring is a process whereby a registered nurse evaluates the level of wellness of a consumer to determine if the consumer is properly using medical health services as recommended by a physician and if the health of the consumer is sufficient to maintain him/her in his/her place of residence without more frequent skilled nursing intervention.

Wellness Monitoring includes checking and/or monitoring the following:

1. Orientation to surroundings
2. Skin characteristics
3. Edema
4. Personal hygiene
5. Blood Pressure
6. Respiration
7. Pulse
8. Adjustments to medication

2. Limitations and Restrictions:

a) Consumers must have medical conditions that require monitoring if they are not receiving skilled nursing care. Only one visit by a Registered Nurse, per 60 days, is covered.

b) A consumer eligible for Wellness Monitoring lives in a non-institutional setting and, through the utilization of Wellness Monitoring is visited no more often than every 60 days, is able to maintain his/her independence at home, or in an alternative living arrangement.

c) The Registered Nurse who provides Wellness Monitoring may also provide nursing care and supervise medical attendants.

3. Provider Requirements:

This service is provided by Registered Nurses only, who may be employed by home health agencies licensed by the Department of Health and Environment, SRS - licensed agencies, public health departments or Community Service Providers. Direct medical intervention is obtained through the appropriate medical provider and is not funded by this program.

4. Record Keeping:

a) The Registered Nurse must provide the persons' case manager with a brief summary following each visit, indicating how the beneficiary is doing under the services currently provided. With the consumer's written consent, this may also be forwarded to the primary care physician as appropriate.

b) At a minimum, documentation must include the following:

- Consumer's first and last name
- Nurse's name and signature with credentials
- Date of service (MM/DD/YY)
- Clinical Measurements
- Review of Systems
- Additional Observations, Interventions, Teaching issues, etc.

c) Documentation must be created during the timeframe of the billing cycle. Creating documentation after-the-fact is not acceptable. Providers are responsible to insure the service was provided prior to submitting claims. If documentation is not clearly written and self-explanatory, the services billed will not be paid.

5. Billing for Wellness Monitoring:

Providers are responsible to insure the service was provided prior to submitting claims.

This service is billed per visit at a rate of $_____.

Procedure Code: S5190

FY2011 HCBS-MR/DD Reimbursement Rates				
Service	**Procedure Code**	**Provider Type**	**Specialty**	**Rates**
Residential Supports				
Regular Tier 1	T2016	55	364	$160.21
Regular Tier 2	T2016	55	364	$131.22
Regular Tier 3	T2016	55	364	$94.86
Regular Tier 4	T2016	55	364	$61.26
Regular Tier 5	T2016	55	364	$44.27
Residential Supports				
Super Tier 1	T2016	55	364	$192.05
Super Tier 2	T2016	55	364	$171.36
Super Tier 3	T2016	55	364	$152.56
Super Tier 4	T2016	55	364	$133.74
Super Tier 5	T2016	55	364	$114.55
Day Supports				
Regular Tier 1	T2020	55	520	$99.53
Regular Tier 2	T2020	55	520	$73.60
Regular Tier 3	T2020	55	520	$59.19
Regular Tier 4	T2020	55	520	$43.55
Regular Tier 5	T2020	55	520	$37.37
Day Supports				
Super Tier 1	T2020	55	520	$120.87
Super Tier 2	T2020	55	520	$111.12
Super Tier 3	T2020	55	520	$102.36
Super Tier 4	T2020	55	520	$93.31
Super Tier 5	T2020	55	520	$85.31
Supportive Home Care	S5125	55	365	$3.06
Respite - Temporary	S5150	55	512	$3.06
Respite Overnight	H0045	55	512	$58.34
Personal Assistant Services	T1019	55	370	$3.06
Supported Employment	H2023	55	369	$3.06
Sleep Cycle Support	T2025	55	368	$30.65
Specialized Medical Care (RN)	T1000TD	55	521	$7.50
Specialized Medical Care (LPN)	T1000	55	523	$7.00
Medical Alert Rental	S5161	55	268	$15.00
Wellness Monitoring	S5190	55	517	$35.00